Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN445AGC	A. BUILDING _____ B. WING _____	09/14/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHISPERING WILLOWS	803 RALSTON ST RENO, NV 89503

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual licensure survey conducted in your facility on 9/14/10. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for 10 Residential Facility for Group beds for elderly and disabled persons, five Category I residents and five Category II residents. The census at the time of the survey was nine. Nine resident files were reviewed and four employee files were reviewed. One discharged resident file was reviewed. The facility received an annual survey grade of A. The following deficiencies were identified:	Y 000		
Y 300 SS=E	449.218(1) Bedrooms - Size Requirements NAC 449.218 1. A bedroom in a residential facility that is shared by two or three residents must have at least 60 square feet of floor space for each resident who resides in the bedroom. A resident may not share a bedroom with more than two other residents. A bedroom that is occupied by only one resident must have at least 80 square feet of space.	Y 300		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 300	Continued From page 1 This Regulation is not met as evidenced by: Based on observation and interview on 9/14/10, the facility had one bedroom shared by four residents. Severity: 2 Scope: 2	Y 300		